



THE COMMONWEALTH OF MASSACHUSETTS

Department of Industrial Accidents

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Boston, Massachusetts 02111

JAMES J. CAMPBELL
Commissioner

CIRCULAR LETTER NO. 274

TO: Insurers, Cities, Towns and Municipalities, (Collectively “Insurers”), Self Insurers, Utilization Agents, And Other Interested Parties

FROM: James J. Campbell, Commissioner

RE: Utilization Review and Quality Assessment program and Requirements:

1. Enforcement
2. Issuance of Identification Cards
3. Application Amendments and Notification Requirements
4. Clinical Data Sheets
5. New Claim Form
6. Purchase of Ancillary Services
7. Reporting Form Requirements/Restorative Therapy

DATE: November 24, 1993

Pursuant to the provision of M.G.L. c. 152, § 30, as most recently amended by St. 1991, c. 398, § 53, utilization review and quality assessment regulations relating to the provision of adequate and reasonable health care services were promulgated on June 18, 1993, effective July 1, 1993. Circular Letter No. 270, advising of the program and its requirements was sent to over 4,000 insurers, self-insurers and other interested parties in July, 1993.

The regulations, 452 CMR 6.00 et seq., require insurers and self insurers to undertake utilization review for health care services rendered to injured workers on or after October 1, 1993, either by performing utilization review themselves or by contracting with agents who provide utilization review services. If an insurer or self-insurer performs utilization review itself, it must have its program approved through the Department of Industrial Accidents (the “Department”), as do individual Review Agents.

I. ENFORCEMENT:

The importance of compliance with these requirements cannot be stressed enough. The Department is charged with the implementation of the Workers’ Compensation Law. St. 1991, c. 398, and regulations promulgated pursuant thereto, provide enforcement

mechanism to the Department to assure compliance. The Department is prepared to take vigorous action against insurers and self-insurers who fail to adhere to the law and the regulations. Insurers and self-insurers should take whatever steps are necessary to assure full compliance.

Specific enforcement mechanisms include, but are not limited to, the following:

- 1) Pursuant to Chapter 152, § 25A(3), the Department may revoke or refuse to renew the license of a self-insurer for any reasonable cause; pursuant to 452 CMR 5.08, the failure of any self-insurer to carry out the terms of any requirement of the Department shall be reasonable cause for revocation of, or refusal to renew, the license of the self-insured.
- 2) The Department will be promulgating regulations pursuant to Chapter 23E, § 3(b)(8) regarding insurer claims handling practices. It is expected that insurers will facilitate education of and coordination between their adjusters and utilization review agents to facilitate claims handling practices which conform to the utilization review regulations. The Department will refer its findings regarding claims handling techniques and patterns of unreasonably controverting claims directly to the Commissioner of the Division of Insurance for appropriate action;
- 3) Failure to comply with the utilization review requirements of the Regulations may impair an insurer's or self-insurer's ability to defend claims for payment of medical bills which have not been put to utilization review;
- 4) Failure to comply with the utilization review regulations may affect determinations and filings made pursuant to Chapter 152, § 53A(13);
- 5) The Department will be tracking insurers, self-insurers, and utilization review agents to monitor their quality of service, requiring up to 100% reporting of medical bill information, pursuant to 452 CMR 6.05(2). In addition, the Department will track patterns of payment. In connection with the forthcoming reporting requirements, all insurers and self-insurers must be prepared to report billing information on all medical bills paid, including those cases which were so-called "medical only" or not put out to utilization review; and;
- 6) Pursuant to proposed Massachusetts Assigned Risk Pool Plan of Operation, "Performance Standards for Servicing carriers," Standard B.6.a.: Claims-Medical Care and Cost Control, carriers will be responsible for complying with "utilization review as required by the DIA regulations..." Failure to maintain this and other standards may result in penalties being imposed upon the servicing carrier by the Residual Market Committee in accordance with Article VII of the risk Pool Plan of Operation.

II. IDENTIFICATION CARDS:

The identification cards required to be issued by 452 CMR 6.04 (4) (e) should be issued for existing as well as new claims which occur on or after October 1, 1993. Once the card is issued, the present regulations require an employee seeking care to contact the utilization review agent for approval of treatment. This requirement should not be

interpreted as a need to contact for each and every clinical intervention. Rather, contact should be made to approve a **plan** of treatment within the specific guidelines for treatment.

III. APPLICATION AMENDMENTS AND NOTIFICATION:

Each insurer, self-insurer, and Utilization Review Agent which has submitted a Utilization Review and Quality Assessment Program application and has had it approved, must advise the Department's Office of Health Policy in writing of any material changes to required information, including which insurer(s) and/or self-insured(s) the approved Utilization Review Agent is performing services for and/or whether utilization review is being done in-house.

Insurers and self-insurers not approved as Utilization Review Agents themselves must notify the Office of Health Policy of the Utilization review Agent(s) they are using to comply with 452 CMR 6.00 et seq.

IV. CLINICAL DATA SHEETS:

Utilization review criteria worksheets, mirroring the review criteria to the Department's treatment guidelines, for use by all parties in the Dispute Resolution process, are available at the Department through the Office of Health Policy.

V. NEW CLAIM FORM:

A new claim form to be used for all utilization review claims is now under production and will be distributed by circular letter when the form is available.

VI. ANCILLARY SERVICES

It must be stressed to all Utilization Review Agents, insurers, and self-insurers, that 452 CMR 6.00 et seq. are regulations and requirements for the performance of utilization review and **not related services**. Should an insurer or self-insurer purchase ancillary services such as managed care, case management, independent medical exams and/or rehabilitation services from vendors who are also approved as Utilization Review Agents, **they do so by their own choice**. Said ancillary services are not to be considered utilization review requirements or expenses. Moreover, these additional services should not be construed as approved by the Department by virtue of the Department's approval of the same vendor to perform utilization review.

In order to ensure that excessive, duplicative or misleading billing, planning or other business activities are avoided or eliminated, insurers and self-insurers are reminded of their obligation to monitor both their own internal practices as well as the practices of their utilization review agents, especially those agents, especially those agents hired to provide services ancillary to utilization review.

VII. REPORTING FORMS/RESTORATIVE THERAPY CODES:

Pursuant to 452 CMR 6.05 (1), you are reminded that beginning January 1, 1994, providers must use, and insurers and self-insurers must accept, only UB 92 and HCFA 1500 billing forms for workers compensation claims. Hospital providers are further reminded that, when billing for restorative therapy services, only Rate Setting Commission approved "Hospital Revenue Codes" describing services in time units should be used in column 42, "Rev. Co.," of the UB 92 Form while applicable CPT-4 Codes describing the specific restorative services(s) provided must be included in column 43, "Description," of the same UB 92 Form.